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ABSTRACT

Organizational structure, educational objectives, and general information are presented on educational programs for the mentally handicapped in Denmark, Sweden, and Norway. The basic goal of Scandinavian programs for the mentally handicapped is normalization, with emphasis on social adjustment to prepare retardates for assimilation into community living. Description of Danish programs covers institutional facilities, residents' living quarters, sexual needs, sheltered workshop training, affiliated social workers, hostels, hostel pensionet for 11 mentally retarded couples, Society and Home for the Crippled, special education at Rodovre, and the National Parent Organization. Discussion of Swedish service facilities covers County Council responsibility, individual normalization, several institutions, sexual needs, activities of daily living, sheltered workshops, and staff. Outline of Norwegian programs includes program responsibility for the mentally handicapped on the basis of IQ, private organizations, national organization, craft work, religious teaching, vocational skills, and development of self reliance. Concluding the study are Scandinavian information sources on institutions and agencies, individuals, mimeographed material, and brochures and publications. (CB)

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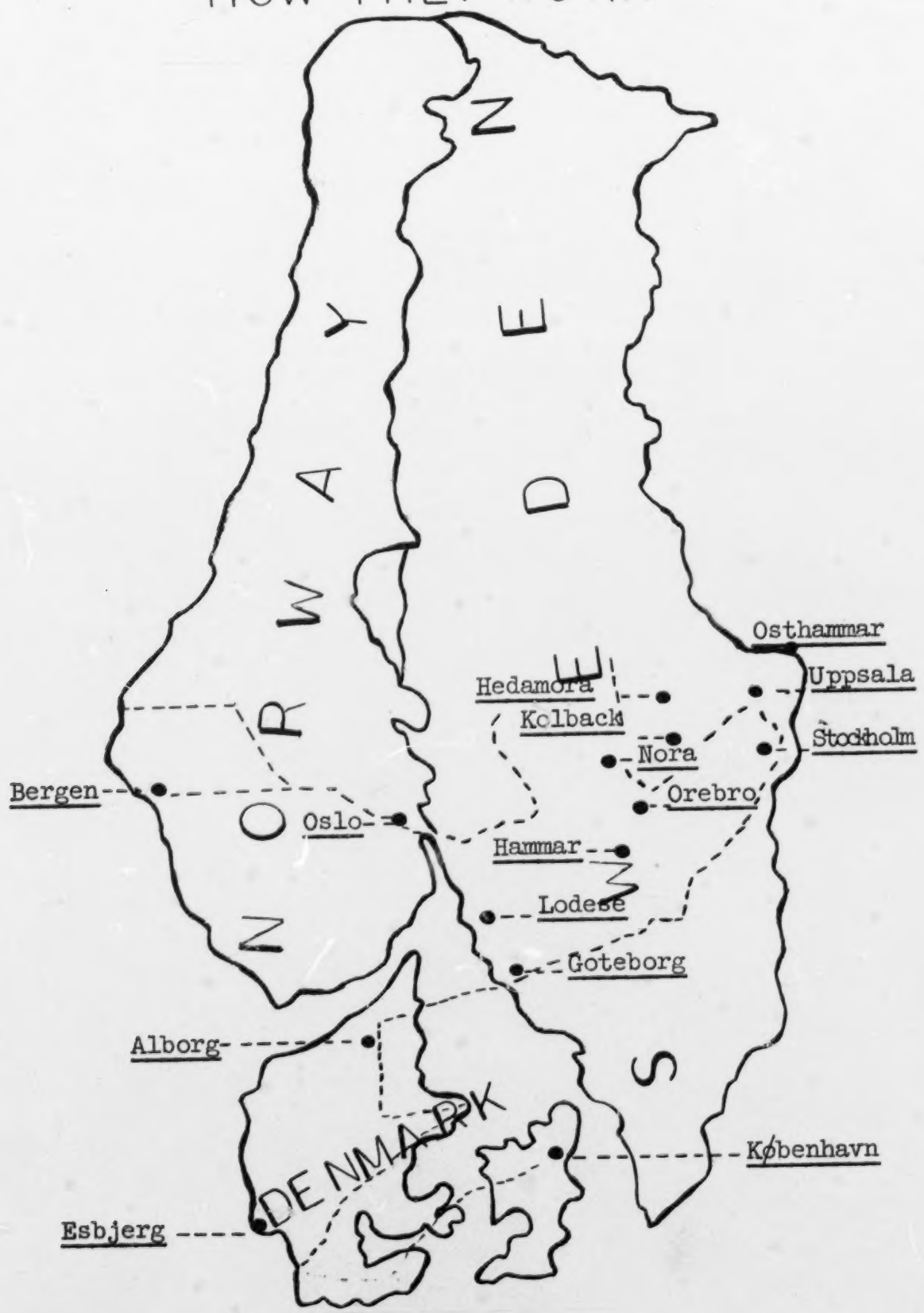
SCANDINAVIAN PROGRAMS FOR THE MENTALLY RETARDED

HOW THEY WORK



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SCANDINAVIAN PROGRAMS FOR THE MENTALLY RETARDED

ARE THEY REALLY AS GOOD AS THEY SAY?

Summer 1970

Mary Jane* and Kenneth Clark

It was in the early 1950's that many of the western nations, as well as many of the states in the United States and provinces in Canada, acknowl-eged the fact that they were not providing their mentally retarded with adequate services, and they set about to make amends. The fact that so many programs, in so many parts of the world, were started at nearly the same time did not result in a race to see which one could be the first to claim that they were providing all of the services and opportunities to which their mentally retarded were entitled.

It does, however, provide a study in motivations that brings about sustained progress. The effect of varying cultural backgrounds and economic bases have also affected the programs and the speed with which they were imple-mented. No two of them are duplicates. Those who are administering these programs can, and do, point out short-comings. But, in nearly every case, even in the economically depressed countries, they have developed some aspects of their programs which are superior.

It is for this reason we have devoted our vacation time for several years to study what is being done in other countries. What are they doing differently (or better) than we have observed elsewhere? In previous years we have made such studies in Portugal, Spain, Italy, Yugoslavia, Austria, Germany, Holland, Mexico, and then in three western provinces of Canada--Saskatchewan, Alberta, and British Columbia.

It was about ten years ago that professionals in the field of mental re-tardation began to hear about the programs that the Scandinavian countries were developing. Professional journals were full of glowing reports about unbelievable programs which they were initiating. We felt that by now (the summer of 1970) they should have completed their trial-and-error stage, and now provide proven methods of assisting the mentally retarded in the most effective ways.

GENERAL INFORMATION

We spent five weeks, during which time we visited about 30 institutions in Denmark, Sweden and Norway. The ones which we visited were selected so as to provide us with a cross-section of all of the institutions in that

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country, old and new, for retardates ranging from profoundly retarded to the educable, and also both urban and rural.

Because of their proximity, similar language and cultural background, there are similarities in the ways in which they have accepted their responsibilities towards their mentally handicapped, and the ways in which they have set about to fulfill these responsibilities. So as not to repeat these similarities in our reports dealing with each of these countries, we will first tell of these common characteristics, and then report on their individualized application in each of these countries.

To understand Scandinavian programs for their mentally handicapped it is necessary to know that their underlying goal is normalcy. This, as defined in The Mentally Retarded In Sweden is:

> "The basic aim in all care of the mentally retarded is normalization. The principle of normalization is applicable both to the development of the retarded individual (child or adult) and the needs of the parents in respect of service and to the function of institutions, etc.
>
> "The validity of this principle is not negated by the fact that the majority of retardates cannot be fully adjusted to society. The term implies rather a striving in various ways towards what is normal. Nor does it apply only to the individual; even an institution, in fact the entire system of care as such, can be 'normalized.' The principle of normalization applies in reality to all children and young people, the difference in their capacity for adjustment to society being purely quantitative. Even the most severely handicapped person can thus be 'normalized' in one or more respects.
>
> "Normalization does not imply any denial of the retardate's handicap. It involves rather exploiting his other mental and physical capacities, so that his handicap becomes less pronounced. It means also that the retardate has the same rights and obligations as other people, so far as this is possible.
>
> "There are, of course, mentally retarded persons who should not be forced out into society, for humanitarian reasons. However, these most severe cases of mental retardation must not, as previously, determine the sort of help given to the majority."

All of their various programs are designed to implement this goal.

The most visible way in which they do this is by the living arrangements they provide for those living in residential institutions. They have ample-sized rooms, usually for single occupancy though in some cases, for double

occupancy. The rooms are comfortably furnished and attractive. It is their home, and they can, and do, decorate them as they please.

All of the handicapped can receive a pension. In the cases of those living in residential institutions, much of this goes to the institution, but there is always a portion that goes to the resident for him to use as "pocket money." Many save this money to buy radios, tape recorders, and in a few cases t.v.'s. Many also save their allowances to take vacation trips.

The Scandinavian attitude regarding sex is quite different from the standards which we, in this country, endeavor to impose on our mentally retarded. Their thinking is this: Sex is a part of normal living; retardates cannot live normal lives if they are forbidden to participate in one aspect of normal life. The fact that this report will mention sex, and how it fits into their normalization process, is not to be construed as an obsession on our part. It is reported because it is different from our accepted policies, and can be considered as part of their therapy.

D E N M A R K

It was during the middle of the past century that several of the European countries, as well as Massachusetts in this country, established the first residential treatment centers, specifically for the mentally retarded. In Denmark this occurred in 1855 by a private organization. In 1933 the National Assistance Act defined institutional care, treatment, education, foster-home care, etc., as the responsibility of the Danish Government. This was updated by the National Assistance Act of 1961. This Act sets up an eight member board of directors, one of whom is the president of the national parent organization.

The structure by which services are provided, and the philosophy that underlies them can best be obtained from the following excerpts from General Survey and Brief History of the Development of Service Systems in Denmark (1969):

> "Entitled to receive help and assistance from the Service are those who are or appear to be mentally retarded and also appear to be in need of special services. Public authorities, physicians, teachers, etc., who through their activities are in touch with the mentally retarded or other handicapped persons, are expected to furnish reports to the Service.
>
> "The Service is required to give guidance to parents on the care, treatment, etc., of their mentally retarded children, and on existing facilities for help and assistance."

As an assurance that all mentally retarded children receive assistance when it will be most beneficial, there is a provision whereby authorities

within the Service may initiate action when they learn of a mentally retarded child for whom assistance has not been requested, with the consent of the child-welfare authorities.

ORGANIZATION

The entire organization for the provision of services is governed by an eight man board of directors appointed by the Minister of Social Affairs. One of these directors must be the president of the national association of parent groups. This national board of directors has supervision over the 12 regional centers. These are, in turn, directed by a five member board of control, one of whom must be the representative of the parent association in the area served.

HOW THIS SYSTEM FUNCTIONS

As the proverb says, "The proof of the pudding is in the eating," we were interested in observing how these theories were being put into practice, and if they were accomplishing their purpose--namely to provide as near as possible a normal living pattern for those receiving assistance, and to assimilate as many of these retardates as possible into the community.

To do this, we visited about 30 institutions in the three Scandinavian countries. In each of these we were told about their programs, and observed many of them, whereby each of these institutions was fulfilling its responsibility to provide an essential part of this over-all pattern. There was not one of these that we did not find to be interesting. Nor did we observe many instances where we, in our judgment, did not think that they were providing their functions in a manner superior to those which we had studied in other countries.

Because we found each of these facilities to be interesting, we would like to describe each of them in detail. The reason we will not do so is because it would make this report so lengthy it might discourage some people from reading it. As the purpose for going to the expense and effort of making this survey is to acquaint as many as possible interested people in knowing about other and different ways of assisting the mentally retarded, we would like to make the reading of this report as inviting as possible. We will, therefore, describe the over-all structure, and enough of the units to illustrate how their systems operate.

A secondary purpose for this report is to motivate interest by professional workers with the mentally retarded of Scandinavian programs--within the scope of their special interest. And, to provide them with information as to where things are being done differently, (and maybe better), in hopes that they will also visit these places, and make studies in greater depth. Denmark has about 1,000 foreign visitors a year who come to study their programs, and Sweden has about 500 such visitors each year. For the assistance of such people, we are listing in the appendix of this report,

the names and addresses of institutions and individuals from whom we obtained our information.

The Danish system requires that there be one central institution for the mentally retarded in each region, with as many satellite facilities as are required to meet the needs of the retardates in the area which it serves. The efficiency with which this system provides a wide range of services can be illustrated by a description of this network around Copenhagen.

Because of the large population which is served, there are two central institutions in Copenhagen. Vangede cares for about 300 residential patients from infancy to about 15 years of age. Then, if continued residential care is needed, they are transferred to Lillesmosegard, an affiliated institution about one-half mile away.

One's first impressions at Vangede are of its buildings and grounds. A few of the buildings are old and have been converted into classrooms. The major portion was completed in 1965, and consists of single-story, brick buildings. The residential units are so designed to group seven--in most cases, double rooms, together with a living room and dining room. These units, in turn, are connected by inside corridors with adjoining units. This makes passageway possible from one part of the building to another without being exposed to inclement weather, such as they sometimes have during the winter.

Also included in one's first impressions is the fact that all of the buildings have an unusually large number of large windows, and that there are flowers nearly everywhere, both inside and outside.

As mentioned, most of the residents live in double rooms. The exception is that some of the profoundly retarded may be in rooms for four or five, to facilitate in providing them with the close supervision which they need. A visit to these rooms is a lesson in creativity. Every room was colorfully and attractively decorated. There was nothing about them to give any impression of being in an institution. As throughout Scandinavia, everything was immacuately clean. An unusual feature, which we found only here, the cleaning is done by contract with a private contractor.

A large proportion of the residents are cerebral palsied, many of whom are profoundly retarded. Nearly all of these have tricycles especially designed to their individualized needs, and built at a sheltered workshop for the physically handicapped. With these, they can get around, both inside and outside, when weather permits. We saw practically none in bed.

We visited this institution on a pleasant, early June day, and were interested in seeing many of the young, attractive physical therapists who had their young cerebral palsied children out on the lawn where they were exercising their arms, legs and spines. The therapists were dressed in brief gymnasium tights. In addition to the residents who receive treatments, such as this, about 35 children who live in the area are brought to the institution for the day. They are transported in buses in which they can be strapped.

Attached to each basic core or unit of from 10 to 14 children, are two teachers--one male and one female. In addition to these, there are specialists in various fields who are also involved in providing pedagogical training, making a total of full and part-time staff of 45.

Here, as throughout Scandinavia, minimum regard is paid to IQ's. The stress is layed on social adjustment. In the schools less emphasis is placed on teaching academic subjects than on Activities for Daily Living (ADL). The obvious purpose of this is to prepare as many retardates as possible for assimilation into community living.

Lillesmosegard, as stated, receives residents from Vangede when they reach the approximate age of 15. They remain here as long as necessary, in some cases for the remainder of their lives. There are 14 intramural residence units, in which the residents live and eat as families. Food for Lillemosegard, as well as for Vangede, is prepared in a central kitchen and delivered to the various units. The units are small so as to maintain a family atmosphere.

The residents of 13 of the 14 units are kept occupied during the day in sheltered workshops doing lawn and garden work. There are several workshops, and the one devoted to ceramics is outstanding. Much creativity is used by the residents in making tile wall decorations. We observed these wall decorations in many places we visited in Denmark. We were told that there is a ready market for all that they produce. Another item with a good market is their colorful shag rugs made with wool yarn. Even the more severely retarded can work on these as long as the instructor draws the outlines on the base material.

Not all of their time is spent working. The government provides pensions for all registered mentally retarded. In the case of those who live in residential institutions, most of this pension goes to the institution to cover the cost of their care. But there is always a separate amount that goes to the individual for his personal use. They refer to it as "pocket money." They can also earn additional money from their work in the workshops. With this, they can, if they choose, buy special furnishings for their rooms, as well as radios, tape recorders, etc. But, the big inducement for them to save is to have enough money to go on holiday trips. Residents from here have gone on trips to many parts of Europe. Just as we arrived to make our visit, a bus was being loaded with a large number of residents who were starting on a trip to Finland. Excursions may also be shorter. We observed that the young men at one of the workshops were in quite a hilarious mood. The explanation was that they had just returned from a trip to one of Copenhagen's famous breweries. The staff's attitude was that inasmuch as normalization was the goal for their retardates, and so-called normal people visited these breweries and sampled their product, why shouldn't these young men?

We have referred to their latitude in furnishing and decorating their rooms about as they wished. For the most part, they live in double rooms that are very attractive and homelike. The exception is the profoundly retarded who may live four or five in a room. Here they use the ingenuous practice of placing two or three less handicapped in each room to assist the more

handicapped. It not only assists the staff, but more importantly gives these individuals the feeling of being needed.

There is no policy of trying to keep the sexes separated. Residents are free to socialize, and most of the younger girls have been equipped with intra-uterine devices (IUD's).

There are 12 social workers affiliated with this institution. Most of their time is spent not with the 300 patients in the institution, but with the 1,400 cases of retardates living in the community. All retardates recorded in the Registry must be visited at least twice a year to assist and guide them and their parents. Depending upon the degree of their handicap, retardates receive a monthly pension up to about $200. If their handicap is so severe that it requires unusual care from their parents, the parents can receive an additional pension of as much as $75 a month.

There are only two schools in Denmark that train social workers. The result is that there are many more who apply for admission to them than are accepted. Training requires three and one-half years after the equivalent of our high school. The first year is devoted to zoology, psychology, sociology, etc. The second year is spent on two field assignments, and the third year they return to the college for more academic study.

Not all residents at Vangede are transferred to Lillemosegard when they reach their middle teens; those who are more mentally retarded, and who might be classified as profoundly retarded, are transferred to Karens Meide.

This is one of the oldest institutions for the mentally retarded in Denmark which is still in use. It was started in 1884 by Johan Keller who had previously established a national reputation as the director of an institution for the deaf and dumb. His son continued in this work after the elder Dr. Keller became inactive.

The buildings are old, but well constructed. Much ingenuity and imagination has been used to remodel its interior so that it is attractive and very livable for the approximate 100 residents. They have rooms that are colorful and individualized, for either two or three occupants. Even though they are profoundly retarded, all but about six are up and active every day. Those few who are unable to be active, are in wheel chairs that make it possible for them to also be wherever the action is. During good weather, this is frequently on the large grounds surrounding the facility. Here are many large trees to provide shade and flower gardens to supply beauty.

Even though the residents here are severely retarded, they have two very active workshops. In one the residents dye old dresses, sheets, etc., and then tear them into strips which they weave into rugs. The other workshop is the only one of all of these institutions in Denmark where they make candles. The quality of their products is such that they have a ready market for all that they produce. The woman instructor has demonstrated cleverness in designing simple, but efficient and inexpensive equipment. It consists mostly of old bicycle wheels attached to a frame suspended from the ceiling. Wicks are attached to the spokes of the wheels, so when the frame is lowered, many wicks can be dipped by turning each wheel, and

then the whole frame. Then they are raised to cool before another dipping.

There are several other institutions in the Copenhagen area, each serving the individual needs of small groups of retardates. Some are so placed because of the type of handicap which they have in addition to mental retardation. Others, because their needs can be met better in a smaller institution.

One such institution, which we visited is Folstrup, located near Fredensborg. This is a new facility on a large lake; across this lake is located the summer home of the king. At present, this institution cares only for women who range in ages from 40 to 80 years. Another group of buildings is nearing completion that will care for a similar group of men. As the women living here are quite retarded, there are definite limitations as to what they can do in the way of occupational therapy, but they are provided opportunities to do whatever is within their limitations..

Several things here attracted our attention. First of all, was the location on a gentle slope down to an attractive lake. The women lived two in a room. All of the rooms were of very ample size, comfortably and attractively furnished, with large windows opening onto nicely landscaped grounds.

Relatives of the women living here are provided train fare by the state to come here to visit them at frequent intervals. Once each year, arrangements are made for these women to go on conducted tours with normal people. These tours may last from one to two weeks.

Another type of need is provided for by hostels, which might also be called halfway houses. One of these which we visited is under the direction of Mrs. Elna Skov. In this large brick house, in a middle-class residential area, are 22 girls, ranging in ages from 18 to 25. They come here from Lillemosegard, and as soon as they have had time to adjust to community living, they seek employment. Mrs. Skov is much more than a housemother. She utilizes her accumulated experience and skills from working with the mentally retarded for many years in assisting these girls to achieve complete independence. She does this in many ways. One, which has proven successful, is role playing. For instance, she will have one of the girls talk on an extension phone while she is on her office phone. The girl is taught the proper way to answer, and common courtesies in talking over a phone. She conducts employment interviews with individual girls. She will go on shopping trips with one of them, but, when they get inside of the store, she will ignore the girl--unless she is actually needed.

Even though some of these girls have IQ's as low as 30 (though most are between 50 and 70) all are, or will be soon after coming, employed. They earn anywhere from about $24 a week to $40 a week. From this they pay about $12.25 for board and room. The state makes up the difference between this and the actual costs.

Most of the girls have been fitted with IUD's, though two have been sterilized. Rather than have the girls having an affair in some dark store entrance, she permits them to entertain their established boyfriends in their rooms. She says that there have been no pregnancies.

Another hostel which we visited is for 19 young men, ages 18 to 24, and it is under the direction of Mr. Neilsen. His background is rather unusual for this position in that he had been on the police force for twenty years. This we found was typical of the Danish policy of not relying overmuch on academic training, but placing major emphasis on capability. Mr. Neilsen has been the director of this hostel for about four years. It is located in a mixed neighborhood of retail supermarkets, a school and some very nice homes. It consists of a large brick house with a large and attractively landscaped yard behind it.

About half of these young men come here directly from their homes, the other half from Lillemosegard. The first two or three weeks are devoted to adjustment and feeling at home in these new surroundings. Then they are assisted in finding employment in whatever field they appear to have potentialities and will be happy doing. Many do not stay on their first assignment, but a sufficiently good reputation has been established with employers in the area so that they phone in more requests than the hostel can fill.

The director carries on a continuous program with these young men to prepare them for independent living. He counsels them on the use of their money. He will not handle it for them, but advises them on the wise use of it, and the banking of all that they do not need. One incentive for saving is their enjoyment of vacation trips to other countries. One or more of them have visited nearly every country in Europe. By using these and other methods these young men are ready to move out in two to three years. At first they return for morning and evening meals, and a box lunch; then they return only if they need counseling.

An unusual and effective method of cooperation between the parents of these young men and the director has been developed. The parents have formed an organization and selected three of their members to represent them at monthly meetings with the director. They discuss items that they think are needed. If there is agreement, the three parents then contact the other parents in an effort to provide whatever they feel is needed. Based upon our observations, it appeared to us that there was little, if anything, that could be added to the large comfortable living room and the attractive, double-occupancy bedrooms, that was needed to add to their livability. Maybe this situation will change in the near future, as they hope to enlarge this unit so that it will provide for sixty young men and a few young women.

HOSTEL PENSIONET

This is a facility for 11 mentally retarded couples. It consists of two floors in a large, high-rise apartment complex. The wives have either been sterilized or are on the pill. Because it is necessary for a retarded person to obtain dispensation from the Ministry to marry, and this takes considerable time, one couple is permitted to live together as man and wife while awaiting this dispensation. The one hundred or more other apartments are occupied by normal people.

Here, too, the residents pay the usual 92 kroner per week. This covers both

their rent and food. In addition to the director, there are three aids who function as social worker/nurse, on a 24 hour basis. These aids are required to have a three-year, college-level, training.

OTHER INSTITUTIONS

Many of the mentally retarded remain in their own homes, and a wide variety of institutions are available to provide them with assistance in achieving self-sufficiency and opportunities to live normal lives.

SOCIETY AND HOME FOR THE CRIPPLED

The Society and Home for the Crippled, an independent organization, subsidized by the government, has a number of facilities scattered throughout Denmark. Some of these care for special categories of crippled persons, such as spastics, those with multiple sclerosis or rheumatic diseases.

We visited one of their workshops for men in Copenhagen. All types of handicapped young men come here for training, a very large number of them are CP's. We were impressed by the wide spectrum of vocations available to them, depending on their limitations and interests. These ranged from tool making to clock making. These included such trades as painting--both furniture and houses, electronics--including television repair and numerous others. We were interested in learning that it is here that many of the specially designed tricycles, etc., used by the handicapped in other institutions, are constructed.

SPECIAL EDUCATION SCHOOL AT RODOVRE

This is one of two schools in the Copenhagen area for mentally retarded children who neither go to the central institution for their training, nor find the special education classes in the public schools to fit their needs. This school is located in a middle class, residential suburb of Copenhagen, but is the only institution which we visited where we and the staff agreed that the building was inadequate for their needs. This one was constructed as a factory building, and has been remodeled, but still does not measure up to the high standards of other facilities which we visited.

Forty children are brought to this school by bus. We arrived just as one of these buses was unloading and were amused to observe a middle teenage mongoloid boy get off smoking a pipe.

The school administrators have found it best to group these children according to their chronological ages, but these groups are then broken down into categories depending upon their social, physical and academic capabilities. In whichever of these areas the child is lowest in, that is the area in which he will receive the major attention, to bring him up to the highest level of which he is capable.

No one technique is used in teaching, instead, the teachers are familiar with most of the methods which have been developed in other countries, and have either adopted or adapted whatever part of these they feel to be useful.

The children are first taught self-identification. Then they are taught academic skills and social skills, with a major emphasis on ADL. For instance, two children from each group will be selected each day to go to the market with their teacher. There they will select and buy food for the noon lunch for their group. Each such group has a small kitchen where they prepare and serve the food which they had bought. The class is responsible for cleaning up the kitchen after the meal. This gives all of them practical experience in many areas of ADL (Activities of Daily Living). Those who cannot be taught to read, are taught to identify signs so as to be able to get around on the streets safely. There is some vocational training, but this is mostly occupational therapy.

Parents are requested to come to the school once a month, and the teachers are allocated four hours a month for conferences with them.

Because of the vulnerability of the teenage students in this school, the director was questioned regarding their sex instruction and other means used for their protection. She explained that they provide them with as much instruction as possible, because they recognize the problem. She said that there have been situations of their students experiencing difficulty because of their becoming too stimulated. In these cases, in consultation with their parents, the family doctors have prescribed medication. In other cases they have been told that if the stimulation becomes too disturbing to them, that there is nothing wrong with their reducing this stimulation, quietly and privately, by masturbation.

NATIONAL PARENT ORGANIZATION

The National Society for the Mentally Retarded has both local and regional organizations throughout Denmark. They also have a national organization, of which Mr. Albert Christensen is the president. By statute he is a member of the Board of Directors of the Danish National Service for the Mentally Retarded.

Although Mr. Christensen is a very busy attorney, he graciously gave of his time to tell us of the activities of the parent organizations. They were started in Denmark about 1950, about the same time that similar groups were being founded in many other countries. He said that they started with about 250,000 kroner ($34,000) in their treasury, and that they now have about 4,000,000 kroner ($550,000).

In the meantime they have established 26 facilities in all parts of Denmark. These included the hostels which we have described. Their strategy is to select areas of need, not presently covered by governmental programs. They establish a facility that will answer this need, then get the government to take it over and operate it.

Mr. Christensen explained their fund raising method. They hold a campaign one day a year similar to our Poppy Day for veterans. This is preceded by a nation-wide publicity campaign on radio, t.v., and the newspapers. The result is that they have generated wide support for both their and the government's programs for the mentally retarded. This has also resulted in their receiving some substantial inheritances.

In response to our questioning him regarding the accuracy of the statement that only 0.9% of the population are mentally retarded, he disagreed with the Registry's figures that there are only about 22,000 retarded. He believes that the true figure is nearer to 50,000.

We asked Mr. Christensen what his thinking was regarding the continued need for a parent organization in a country such as his, where the government is doing so much for its retardates. He was very emphatic in his belief that there will always be a need for strong parent organizations. He explained that there will be a need for governmental expenditures of 100,000,000 kroner a year, over the next 15 years just to meet present and future needs. There will be a continued need for parent organizations to initiate new programs, and facilities to house them as they have done in the past, and then to get the government to take them over.

CONCLUSIONS

Are Danish programs as good as we had been led to believe they are? They have placed primary emphasis on normalization for their mentally retarded. Have they demonstrated that they have accomplished this?

We know of no scientifically accurate method of measuring the degree of normality of anyone. It is much more difficult to do this when the subjects are mentally retarded. We feel that one of Mr. Christensen's remarks may give us a clue. He, who is in contact with parents throughout the country, estimates the total number of retardates to be about 50,000. We were also told by another person that the figure might be as high as 100,000.

This disagreement is, of course, the result of differences of opinion as to who is a mental retardate. If psychometric tests are to be relied upon, and a high enough IQ is established as the dividing line, this will result in a high total. If, on the other hand, determination is based upon their social adjustment and their being integrated into society, then the total will be much lower. That is the goal of their whole program.

Every reasonable effort is made to enroll on the Registry every suspected mental retardate. If tests show them to be retarded, they, and in some cases also their parents, will receive a generous pension. At the same time they are offered opportunities to develop their potentials in residential insitutions, special education schools, sheltered workshops, and hostels. If, and when, they achieve ability to live independently, they are removed from the Registry because they are no longer functioning as mental retardates.

We feel that the way in which one functions is the best test of whether or not they should be classified as mentally retarded. There are so many inducements for being on the Registry that their total must be nearly the total of all of their population who are functioning on a retarded level. In other words, they have, in fact, reduced this portion of their population to close to 0.9%.

S W E D E N

HISTORY

Legislation to provide comprehensive care for the mentally retarded was first enacted in 1954. This legislation was substantially broadened in 1968.

ORGANIZATIONAL STRUCTURE FOR PROVIDING SERVICES

Responsibility for providing services is vested in the County Council, led by a Board for Provisions and Services to the Mentally Retarded. In addition to the 23 County Councils, there are separate city districts for the three largest cities--Gothenburg, Malmo and Stockholm. These boards must include the director of schools for the mentally retarded, the director of care for the mentally retarded and the medical director.

Most of these districts have one central institution, with anywhere from one to several satellites, usually in various parts of the county, which serve the special needs of its residents.

The County Councils currently own 97 residential homes, and also have contracts with 18 privately owned residential homes. The latter care for only about 17% of the mentally retarded living in residential institutions.

In addition to these residential institutions, there are some 200 special schools for the mentally retarded, including those in residential homes. About half of the 8,500 pupils live in their own homes. Many of these schools have boarding-home facilities, enabling those who live too far away to be transported to the school everyday, to live there from Monday through Friday.

Administration of the central institution in each county is by a triumvirate consisting of the medical director, business manager and the chief social worker. We made repeated inquiries to learn if this divided authority caused friction, or had other negative results, but were unable to learn of a single such instance.

Although responsibility for providing services to the mentally retarded rests with the County Councils, coordination and supervision is maintained by the Division of Mental Retardation, National Board of Health and Welfare. This is because they reimburse the County Councils for 75% of their expenditures. Dr. Karl Grunewald, Director of this Division, has three assistants who visit, inspect and review the programs of every institution at regular intervals. This Division also provides assistance in the design of new buildings, etc. An excellent example of the economy and efficiency resulting from this national coordination are the sheltered workshops. Nearly all of the institutions have one. Instead of each one

soliciting contracts, there are salesmen who do this for all of the workshops. They know which ones are equipped to do the various kinds of work, and so can solicit a wide variety of jobs, and then assign them to the shop best equipped to execute them.

Every five years each county is required to submit to the Division of Mental Retardation its plans for the coming five years. But before it is submitted to the national office, it must first be submitted to the county parent organization. It makes its suggestions and criticisms, and returns them to the County Council. These two documents are then submitted together to the national office.

Sweden has decided that the most desirable size for a residential home is one having from 100 to 200 beds. There are still about a half dozen institutions, including special hospitals, for more than 400 persons, the largest (near Stockholm) having as many as 700 residents. Nearly all of the residents live in either double or single rooms. They express their goal for all of their homes as follows:

> "In principle, residential homes should fulfill the functions of an ordinary home. For this reason, living rooms and dining rooms are attached to each department or unit, which must have also such resources of staff and equipment that retarded persons can be trained to a maximum degree of independence, both socially and in the various activities of daily living. Of particular importance is the design of the premises, and of course the qualifications of the staff."

The medical and treatment needs of residents are usually provided either at the institution or in hospitals in the community in which they are located. For those retardates who need specialized care and treatment, there are six regional or specialized hospitals, located in various parts of the country. These provide specialized treatment for those with orthopedic handicaps, impaired vision and impaired hearing.

OTHER FACILITIES

Sweden now has about 40 hostels for the mentally retarded. They correspond to what are called halfway houses in this country. They provide living accommodations in units of 8 to 10 persons, though there may be two units under the same supervision. These residents, for the most part, come from residential institutions, where they received vocational training, and are now employed either in a sheltered workshop or in private industry. Ideally, they will live in a hostel for only two or three years, after this time they will move into a nearby room and return only for guidance and assistance with problems which arise.

Family care (foster care) placements have run into obstacles. One is from parents who find it difficult to accept the fact that the care of their child should be given to another family. Another is the housing shortage; few families have spare rooms.

There are 21 day nurseries in Sweden to relieve parents of retarded children during the day. They care for children up to the age of seven, when compulsory schooling starts. Above this age they can attend the special education schools, referred to above, which provide Monday through Friday boarding school facilities.

UNDERLYING PHILOSOPHY IN PROVIDING SERVICES

In Sweden, as in Denmark, the basic aim in all care of the mentally retarded is normalization. The principle of normalization is applicable both to the development of the retarded individual and to the needs of the parents in respect of service and to the function of institutions.

The principle of normalization applies in reality to all children and young people, the difference in their capacity for adjustment to society being purely quantitative. Even the most severely handicapped person can thus be "normalized" in one or more respects.

Normalization does not imply any denial of the retardate's handicap. It involves rather exploiting his other mental and physical capacities, so that his handicap becomes less pronounced. It means also that the retardate has the same rights and obligations as other people, so far as this is possible.

A relative degree of normalization can be achieved for all retarded persons, in all the various circumstances in which they live, learn, work and undergo care at institutions. Every attempt should be made to achieve the following aims:

Retardates should live in as normal a way as possible, with their own room, and in a small group.

They should live in a bisexual world.

Retardates should experience a normal daily rhythm.

They should work in an environment different from that in which they live.

They should eat in a small group, as in a family, with food and drink standing on the tables.

They should be able to choose between different ways of spending their free time.

Their leisure pursuits should be individually designed, and differentiated according to the time of the year.

The environment should be adjusted to the age of the retardate.

> Retarded young people should be given the opportunity to try out adult activities and forms of life, and be able to detach themselves from their parents.

For the principle of individual normalization to succeed, the following requirements must be made in any institution in which the retardates live:

> That it be organized on the principle of the small group.
>
> That the physical standard of the institution reduces collective facilities to a minimum i. e., in respect to toilets, basins and showers, bedrooms, etc.
>
> That the institution be situated within a community.
>
> That the institution should not be larger than would permit the assimilation of those living there into the community.
>
> That the social contacts of the institution be freely developed in both directions.
>
> That those living there be offered alternative domicile at weekends and at holiday (vacation) times.
>
> And, that the institution should consistantly work in cooperation with parents, relatives and the retarded persons themselves.

It is on the basis of these principles that the care of the mentally retarded is built up and differentiated in Sweden. These principles, they feel, are warranted not only clinically, but also for humanitarian, rational and economic reasons.

They implement the desirability of maintaining contact between the retardate and his family by the following provisions:

> "If the retardated person lives in a hostel, boarding home, residential home, special hospital, or at the cost of the County Council in another private home, then he shall also receive the necessary medical care and reimbursement for travel to visit home once a month. If he is under 21 and cannot utilize his right to such travel, then it can be transferred to the parents, guardian, relative or friend so that they can visit."

A further illustration of Sweden's practice of operating by consensus, is the fact that they have sponsored a national association of the retarded. They have now had two national conferences at which they discuss matters and legislation affecting them. They pass resolutions for changes which they feel will benefit them. These, in turn, are given serious consideration by the National Board of Health.

HOW THE SWEDISH SYSTEM WORKS

The best layed plans and programs have little value unless they achieve the desired goals when put into operation. The purpose of our survey was to observe their comprehensive programs in operation so that we could determine their effectiveness.

Our tour of institutions started in Uppsala, and the first institution which we visited was the central one for the County of Uppsala, called Omsorgs-styrelsen Rickomberga (Board of Special Care for the Mentally Retarded). Our tour was under the supervision of Mr. Henrick Hulbris, the business manager, and Dr. Henrick Swaitling, a psychiatrist who is also the medical director.

This facility comprises three units--a special education school for 60 children living at home, 30 of whom live at the school from Monday through Friday. One of the other units cares for 84 profoundly retarded children, ranging in ages from infants to middle teens. The other unit is for adults.

The profoundly retarded live in a modern building, and all but the most handicapped live in attractive, two-bed rooms. The more profoundly retarded live four to a room. There appeared to be a very adequate supply of ortho-pedic equipment, such as specially designed wheel chairs, tricycles and individualized supports for those who have difficulty in sitting erect.

Ingenuity was shown in one large day room which was furnished with foam rubber chairs. They provide soft, comfortable places to sit, eliminate the possibility of injury to the children, and defy any destructive inclinations.

The major emphasis here is to teach ADL (activities of daily living). In most cases this is limited to social graces such as dressing and feeding, and toilet training. However, there are two classrooms for teaching what-ever academic subjects are within their capabilities.

Our visit coincided with a party celebrating the last day of school. Many of the parents and relatives were there and they and their children sat around tables enjoying the refreshments that were served. The staff encourages such occasions as they provide an incentive for the children to develop socially acceptable manners, and at the same time demonstrate their progress to their parents.

The third unit of this institution is for adults. They live in four long buildings which are designed so as to provide "family" units of seven. This is accomplished by clusters of three double rooms and one single room around a common living-dining room. All of these units in a single building are connected by a corridor, so that during inclement weather it is possible to go from one end of a building to the other through this corridor.

There is segregration as to sex only to the extent of having all of one sex in each "family" unit. We were told that the reason for this was to eliminate the need for more than one bathroom per unit. Dr. Swaitling told us that most of the women residents were either on the pill or had IUD's.

He further explained that though they do not favor promiscuity, they have found that alliances, formed after a reasonably long acquaintance, are beneficial. They can observe this in the grooming, emotional stability and other ways of both parties.

Nearly all of the 84 residents are employed in sheltered workshops. Many of the women work in one devoted mostly to weaving. The looms on which they work are of all sizes, and the materials which they weave vary from simple to very complex. Some of the men work in a sheltered workshop, also located on the grounds, of the machine shop type. Many of these men have low IQ's, but it was here that we observed one of these men operating a hydraulic machine for cutting heavy iron rods to exact lengths. Dr. John Webster, who had been on a Committee of the President's Panel on Mental Retardation, accompanied us on this visit, said that he had never known of retardates operating such machines. The other employed residents work in a sheltered workshop in town, about a mile away. They travel to and from the shop by public bus.

Dr. Swaitling told us that this institution is also responsible for the supervision of about 150 mentally retarded living in foster homes in the area. He and a social worker spend one day a week visiting these homes, providing whatever care and guidance is needed.

The sheltered workshop in the city of Uppsala, referred to above, is AIA Stistelsen. This name in itself is interesting in that the initials, "AIA" mean adjustment to life and work, and, in Swedish, mean "wing." In other words, it means that the trainees are to be lifted by adjustments to work to eventual independent living and employment in competitive employment. The workshop is a demonstration project, sponsored by the national parent group, and is the only one of its kind in the country.

There are about 80 retardates receiving training. Many of them are of lower IQ's than are generally considered to be good prospects for vocational training. They are taught a total of 30 different production operations. We observed them doing a wide variety of these operations, from packaging scouring pads for 3M Manufacturing Company to making parts for Volvo autos.

In addition to their disability pensions, which all handicapped individuals receive who are on the Register, these trainees receive one kroner (19¢) an hour to start with, regardless of how much they produce. As they advance to each of the five levels of skill, they receive an additional 15 ore per hour. So at their top hourly rate, they receive one kroner, 60 ore (30¢).

One interesting (and we think significant) fact, we were told was that when this workshop was started a couple of years ago, they established one restriction on the foremen-instructors that were to be employed--that none of them should have had any previous experience in working with the mentally retarded. They wanted people whose experience had been with normal people, and who would expect their trainees to learn to work to standards maintained in private industry. They are satisfied that this approach works.

In addition to these instructors, there are also two psychologists and two social workers. Also affiliated with this facility are halfway houses, which they call hostels, to provide the trainees with adjustment to living in the community. Before these hostels were established by renting several apartments in a complex of high-rise apartments, a sociological survey was made with the tenants in the other apartments to learn if they had any objections. There were none. Another survey was made after they were established, and no prejudice was found. Two factors may be involved here. One, the consideration on the part of the parent organization that was sponsoring them, to discuss the matter with the other residents in the buildings. The other is the fact interest in, and consideration of, the mentally retarded confers social status in Sweden.

We also visited institutions located at Oregrund, Kolback and several in the vicinity of Orebro. Each of these institutions differed from the others, and had individuality. Yet at the same time, each provided, in its own way, the same basic care and services to its residents. We refrain, however, from describing each so as to keep this report as short as possible. One illustration of this individualized approach was observed at Oregrund. This is a new facility for only twenty adult retardates. These residents are referred to as "guests." They have keys to their rooms, and even the director does not enter until he has knocked, and been invited to come in. They, too, have a sheltered workshop. When the "guests" leave home to go to work, they leave by a door on the opposite side of the building where they live, go around the front of it to this shop, instead of a much shorter route through a door on the shop side of the building where they live. The idea behind this is that normal people leave home to go to work every day, so they are doing the "normal" thing by following as similar a routine as circumstances permit.

At Kolback we were told by the director that about half of his staff go along with the permissive attitude regarding sex for the residents under their supervision. He is in agreement with their thinking, but is not hurrying the others to accept this idea. This illustrates what we were told--that the further away the institution is from Stockholm, the more conservative the institutions are regarding sex.

One of the facilities which we visited in Orebro functions, more or less, as a day care center for 16 to 20 boys and girls, from ages 15 to their lower 20's. Their degrees of mental handicap are such that but little in the way of occupational therapy is provided, and they are not considered good prospects for vocational training. Instead, they are taught things that will assist them in daily living. Much emphasis is placed on training them to think for themselves. The directress does this by encouraging them to argue with her, and if they have aggressions, take them out on her in this manner. We had a good illustration of how well their methods work. When we entered this institution we were greeted by a young woman in her upper teens. She was neatly dressed, and was so gracious in the way in which she greeted us and showed us into the main room, that we were in doubt as to whether she was a student or a member of the staff. It was not until we had been there for a while that we learned that she was one of the students.

This air of self-confidence was not an isolated case. In fact, we observed it in all of the institutions which we visited. We tried to analyze how this attitude was generated. Of course their normalization program, treating them as normal people, contributed to this. But we felt that the attitude of administrators was a major factor. When we were being escorted through facilities by the directors, they were never too busy, or important, to stop and talk to residents who wanted to discuss something with them. They did not "talk down" to them. Instead, the most common way was for them to put an arm around the shoulder of the person to whom they were talking. The result was a rapport between staff and residents that was quite ideal.

Another illustration of how the wishes and interests of the residents are considered is an institution for about 60 women in a facility near Orebro, and located on a large and beautiful lake. The buildings are 50 to 75 years old, and are a considerable distance from any community. One has to take a winding, dirt road through a wooded area for two or more miles to get to it. The government would like to construct a new, modern facility in one of the nearby communities. This would be in line with their current, nation-wide policies. But the women who live here don't want to leave. The buildings were originally the manor house of a wealthy family. In this country, they would be ideal for a deluxe resort for both winter and summer vacationers. The women enjoy both skiing and skating in the winter. So, the government is letting them continue to live there, and we could not help but agree that it would be difficult to find a more scenic and enjoyable place for anyone to live.

In order to round out our study of institutions, we visited a privately owned one in Lodose, a small community about thirty miles north of Gothenburg. Here they care for about 60 children from infants to about seven years of age. Of course it was immacuately clean, as are all places in Scandinavia. There was a high proportion of staff to residents, as they all need considerable care and attention. Even with children as young as these, training was started on ADL. This is started when they are 18 months old, and is taught by two teachers from the University of Gothenburg, under the direction of a psychologist. The children are sent here by the County Council, which pays the owner about $11 a day for their care.

One of the most interesting institutions, to us, that we visited was Bracke Ostergard Pediatric Habilitation Center in Gothenburg. We spent a day in this institution. Some time was spent viewing its specialized facilities, but most of the time learning all that we could from Dr. Ingemar Olow, director.

This institution is one of three in all of Sweden that specializes in physically handicapped children. Up until 1958 it had been operated as a preschool center by a church group. At this time, Dr. Olow took over as its director, and it came under state supervision. The primary interest here is in caring for the cerebral palsied, though they also accept spina bifida and muscular dystrophy patients. Although they do what they can for the last two types of handicaps, it was obvious that Dr. Olow's special interest was in using all of the methods that have been developed elsewhere, plus, those gained from their own experience, in habilitating the cerebral palsied.

He and his staff have studied all of the methods that have been developed in other countries that have shown some promise of success. Though some are better than others, none, in his opinion, provide a sufficient measure of success to be adopted. They have, though, adapted parts of many methods, and select the method or methods that they hope will be the most beneficial in each individual case.

Dr. Olow usually has one or two assistants, recent graduates from the University of Gothenburg Medical College, who are specializing in this field. Together they have conducted many research studies to learn more about cerebral palsy. Some of these studies were on the following subjects:

Methods for evaluation of the physical working capacity of school children with cerebral palsy

Effect of physical training on school children with cerebral palsy

Dynamic and static lung volumes of school children with cerebral palsy

Body composition and nutrition of school children with cerebral palsy

Energy expenditure of school children with cerebral palsy as determined from indirect calorimetry and Somatic adaptation in cerebral palsy.

As a result of all this concentrated study and interest in cerebral palsy, Dr. Olow has accumulated much information on the subject. He said that the incidence of cerebral palsy in Sweden is two per thousand births. As far as cerebral palsy is concerned, he is opposed to the manditory physical/ mental examinations for all four-year-olds in Sweden. It is his thinking that the average of two hours each for these examinations will take up too much of the available doctors' time, and as far as the cerebral palsied are concerned, four years of age is too late to start in treating them. Instead, he has established such good working relationships with all those in his area in the health professions that he is quite sure that the examinations of four-year-olds will not disclose any cases of which he is not aware.

Dr. Olow is definitely not dictatorial nor does he believe that he has all the answers. He emphasized the need to listen to and talk with the parents. He promises them nothing, and criticizes those who, for instance, promise cures in four or five months. Then when cures are not forthcoming, blame the parents because they deviated slightly, on one or more occasions, from the prescribed treatment.

He, and his staff, also spend much time listening to their patients. He is anxious to know what they are thinking. One result is that he is not in agreement with the national policy of complete integration. The motive is good, but he feels that it works to the disadvantage of the handicapped person. He took an example outside of mental retardation and cerebral palsy,

and told of a boy with an IQ of 130 who has no hands. In a regular classroom, with a teacher not specially trained, as are most of them, he just did not fit in. In a special education facility, where each student receives individual attention, this boy could develop to his maximum potential.

Because their brain injury affects them in so many different ways, each patient must be treated differently. Because of the close working relationship which they have with the Gothenburg Medical College and its hospital, they have been able to send patients there for orthopedic surgery. They have also had satisfactory results from having sterotactic operations on ten children. This is a treatment developed in Japan. Dr. Olow works closely with Dr. Carlson, one of the developers of L-Dopa. Because of the similar symptoms of palsy associated with Parkinson's Disease and that of cerebral palsy, it was thought that L-Dopa might be beneficial for them as well.

By selecting those with a marked tremor, it was found that this treatment was helpful to many of them. Sufficient time has not elapsed to pass final judgment as to whether or not this will be an accepted treatment for certain types of the cerebral palsied.

Are there any "bugs" in this comprehensive program of providing such excellent care for their mentally retarded? There is at least one. Much emphasis is placed on preparing the retarded for assimilation into society. Much effort and expense is expended for vocational training and social adjustment. But, after they have been living independently in the community for a while, subject to the same stresses and frustrations that we accept as part of normal living, some of them decide that life back in one of the residential institutions is more inviting than the continued struggle for a living in competitive employment, and return. There is nothing to prevent them from doing so. In other words, the care and living conditions in their residential institutions are so good that it dulls the incentive of some for independent living.

All of these social services are expensive. Though only a part of it can be allocated to their care of their mentally retarded, we were told that taxes, for many of the middle class, total about one-half of their income. Surprisingly though, we heard no more complaints about high taxes there than we do in this country. It would appear that most of the people feel that they are receiving an adequate return on their investment. We did not see any slums in the three countries. Swedish law says that no one in that country shall go hungry. At the institutions which we visited, the residents were fed ample quantities of very good food. Their living quarters would compare favorably with dormitories in our better colleges.

N O R W A Y

Provisions and planning for the mentally retarded in Norway vary considerably from those in the other two Scandinavian countries--Denmark and Sweden. There are many reasons for this. It covers an area about two and one-half times the area of Wisconsin, with about the same population. Nearly 70% of the country is uninhabitable and covered by mountains, glaciers, moors and rivers. Only about 5% of the land is considered suitable for cultivation. This results in their having a lower economic base than the other two countries. Norway also suffered much during the Occupation, from 1940 to 1945. In addition to the loss of civil rights and the draining of its assets, there was also considerable property destruction.

The result of these, and other factors, is that Norway was slower in developing programs for its mentally retarded than the other countries. In 1945 there were only 495 patients cared for in two central institutions and one small home. What has been accomplished since then demonstrates what determination and cooperation can do.

It was realized soon after the Occupation that neither the government or the parents of retarded children, nor their combined resources, would be sufficient to provide the residential facilities, day schools, sheltered workshops and hostels (halfway houses) for which there was an immediate need. They wisely chose to build on a broader base, so enlisted the support and cooperation of as many other organizations as possible. The one which has made a major contribution is the Norwegian Red Cross. All of these groups formed a national organization whose initials, spell HELP.

Private organizations, principally HELP, have constructed most of the institutions, and operate some of them. In addition to funds which it raises in various ways, low interest loans are secured from governmental bodies for construction. Amortization charges are included in the operating costs, which in turn are paid by the counties and state (national government).

This set-up has resulted in a growth of facilities from the 495 cared for in 1945 to 6,376 in residential institutions as of January 1969. There are, in addition, many hostels, summer and winter sports camps and sheltered workshops.

The structural organization for providing services to the retarded is similar to that in the other two Scandinavian countries. Responsibility rests with the counties, but in some cases counties have been grouped together so that the 20 counties have been divided into 10 districts with roughly the same populations.

The districts are reimbursed by the state for 75% of the operating expense, which will be increased to 85% over the next five years, and as a result, exerts considerable control.

Under this plan, each region or area, under the direction of a medical superintendent, is supposed to be self-sufficient, with the necessary

institutions for the care, treatment and education of their mentally retarded. This includes a central institution for the diagnosis, treatment, care, education and habilitation. Under the direction of the medical superintendent is the supervision of all services in the area, including smaller homes, day activity centers, out-patient clinics, sheltered workshops, aftercare homes, and other services necessary for a fully built-up, broad welfare service. In addition there are super-regional institutions for mentally retarded patients with seriously complicated defects or handicaps, such as blindness, deafness or criminal tendencies.

There is no compulsory registration of the mentally retarded in Norway. Instead, services for the mentally retarded are offered to parents, relatives, child welfare agencies and guardians. In addition, all those who have reached the compulsory school age of seven, and who cannot be accepted in the school system because of mental retardation are reported by the school board to the social health system. All of these registrations in turn go to the central files for the mentally retarded. Since the central files were established in 1946 about 9,000 have been registered. Based on studies made by the Ministry of Social Affairs, it is estimated that 3.5% of the population, or about 13,000 individuals, need services for the mentally retarded.

Responsibility for the mentally retarded is divided. Those having an IQ of about 55 are classified as mildly retarded, and are under the Ministry of Church and Education. Those with a lower IQ are under the Ministry of Social Affairs. We were told that sometimes there is confusion in borderline cases. The "mildly retarded" are educated in special classes in the public schools.

Governmental acceptance of responsibility for the care of the mentally retarded was not established until 1949. From then on, the national government, generally referred to as the state, has assumed increasing financial responsibility. New legislation, passed in June 1969, assumes 85% of the operating expense, including debt amortization, by the state. The remaining 15% will usually be assumed by the counties.

This legislation accounts for the growth in accommodations for the retarded from 495 to 1945 to the present total of nearly 6,500. They are cared for in 77 institutions, ranging in size from those caring for as few as eight to the largest which cares for about 300. Nearly all are owned by volunteer groups, but operating expenses are reimbursed under the above arrangement.

HOW THE NORWEGIAN SYSTEM OPERATES

To observe how this program functions, we first visited Ragna Ringdals Daghjem in Oslo. This institution is divided into two units. One is an observation center that provides residential care and diagnostic facilities for about 80 small, severely handicapped children. Many of these are cerebral palsied. The other unit is a day care center for 145 children and grownups. These two units are owned by HELP.

At the day care center the children are brought to the school by four buses, also owned by HELP. These pupils range in IQ from 55 and down. Judging from appearances, most of them would be classified in this country as being either profoundly retarded or trainable. We were told that much more reliance is placed on social adjustment than on psychometric tests.

The day begins in the day care center with all of the pupils assembled in one large room, where there are prayers, singing and a story by either the director or some other member of the staff. Then they divide up into small classes, largely determined by their social development. This in turn determines the content of what they are taught. In all cases the emphasis is upon teaching them, within the limits of their capabilities, whatever will be of most value in their daily living. This is illustrated by using the same practice as described in the special education schools which we visited in Denmark. Pupils in various classes take turns in shopping for groceries, and then prepare them for their entire class for their noon meal.

As in other institutions for the mentally retarded, they do considerable craft work. A very interesting example of this is displayed near the entrance. There is a small, framed, finger painting, done by one of the students. Along side it is a large (about six by eight feet), wool shag rug, done also by students, which faithfully reproduces the finger painting.

They have found religion to be a valuable ingredient in the lives of their pupils. A Lutheran pastor comes once a week to teach religion. Last May, 16 pupils were confirmed in his church. This was the first time that they have been confirmed at the same time, along with other children. They are encouraged, and most of them do, attend regular Sunday services with their parents. They have found religion to be helpful to these children. It teaches them to love and help one another. They believe that this is demonstrated by the consideration shown by the older students in looking out for the younger children, and by the help given by the stronger children to the more handicapped.

A social evening is held one evening a week from 7:00 to 10:00 p.m. Entertainment consists of dancing, singing and role playing.

According to one of the social workers, sex does not play as prominent a role in Norway as in the other two Scandinavian countries. She told us that whenever there appears to be a need, one of the workers talks with a girl and her parents. If there is a consensus that a need for protection exists, the girl is either provided with pills or more often, fitted with an IUD. We did not learn of any similar program for dealing with boys and men.

The per capita cost at this day care center is 66.3 NK, about $9.30. This includes their summer and winter vacations. Last winter 72 pupils spent one day a week at one of the four chalets owned by HELP, where they went to ski. The same chalets are used for summer vacations of four weeks each.

The diagnostic-observation unit has a special section for PKU children, where they are provided special diets, and the care which will, in most cases, make it possible for them to eventually return to their own homes and normal life.

In the section devoted to the cerebral palsied, we were impressed by the work of a remarkably clever carpenter. He has devised and constructed chairs for the individual needs of each patient. These chairs are designed and constructed so as to provide the necessary support for them to sit erect. These fit in with their policy of having every child, if possible, up and out of their beds during much of the day.

This facility also provides out-patient care and, during the summer when some of the children go home for school vacations, provides care for children who live at home to stay here while their parents go on vacations.

Fossheim Verksteder is a sheltered workshop, also owned by HELP, and operated under governmental supervision. It is a well equipped and housed facility for 56 trainees, with ages from 18 to 45. Their IQ's range from about 42 to 65, and many of them have such multiple handicaps, in addition to their mental retardation, as epilepsy and being hemiplegic.

Though the major emphasis is on teaching vocational skills, a secondary emphasis is placed on teaching ADL. For this purpose, a teacher from the educational system, spends one and one-half days a week here. ADL training here includes such things as bathing and personal hygiene. They are taught how to take showers, and as some of them will be living in homes without showers, how to bathe using a wash bowl. They are also taught to keep their clothes clean, and to provide them with experience in doing this properly. They are encouraged to bring their soiled clothing to this center where they can launder it with modern equipment, and without embarrassment.

The director is very much interested in developing the self-reliance and self-respect of his trainees. He will not permit anyone to "talk down" to them, or treat them differently than they would treat other people. They are taught social skills, how to get around in the city, and how to find addresses. He explained that he will take the men trainees shopping individually, when they need articles of clothing. After they arrive at the store, he will ignore them, but they know that he is available if they need his help or advice.

The trainees make year around use of two affiliated camps. This camping experience not only provides them with outdoor recreation, skiing in the winter, hiking in the summer, but also provides them with an opportunity to get rid of their aggressions.

This is accomplished either by hard work around the camps or for farmers in the neighborhood. The long days of hard work do not use up all of their energies, so they also enjoy evening recreation. Both men and women trainees attend these camps at the same time. It costs an average of $4.20 for each day that these trainees are in camp, but they are required to pay only 70¢. The difference is assumed by the government.

Since this workshop was started about seven years ago, they have had a total of 133 trainees, 29 of these are now employed in the competitive labor market.

SUMMARY OF NORWEGIAN PROGRAMS

As indicated above, Norway got a late start in developing programs for its retarded, and has had to overcome many difficulties. To offset these obstacles, it has a valuable asset--the desire of a large portion of its population to bring its standards of care for the retarded up to that of its two neighbhors.

We saw this being illustrated one Sunday when we were visiting the Kon Tiki Museum and noticed a large number of crippled young people going into the building. Upon inquiry, we were informed that they were cerebral palsied, and that this was the one day a year that one of the Oslo service organizations took them on a tour of such museums. We were also told that at a recent meeting of Lions Clubs they had raised, in a single evening, 7,000,000 kroner, ($980,000.00) for the mentally retarded.

The Minestry of Social Affairs estimates that about 3% of the population is mentally retarded, but that only about .3% are profoundly or severely retarded. They recognize that adding 300 to 400 accommodations for the latter per year still leaves much more to be done.

From their publications and from talking to governmental administrators, we learned that they recognize several problems which they must overcome.

There is need for residential facilities to accommodate school children from Monday through Friday who live more than 30 kilometers (18 miles) from special education schools. Such facilities would then be available to parents with retarded children who want to leave them there while they take a week-end holiday.

They say that the most important factor of all is to increase the number of highly qualified personnel. They state:

> "The substantial increase in research in the past decade makes it particularly urgent that the services for the mentally retarded are staffed so that it may be possible to utilize all the new discoveries in the daily work. Today there are only 14 doctors, mostly psychologists, child psychiatrists and pediatricians, on a full time basis within the services for the retarded. It is estimated that at least 75 doctors are needed. There is also a need for far more psychologists, social workers, psysio-therapists, vocational therapists, and other qualified personnel. Today there are just slightly more than 100 kindergarten teachers and a similar number of special teachers working within these services. Far more are needed. The ward personnel create a special problem."

Where a government and its people face its problems as squarely as do the Norwegians, we have no doubt but what there will be a constant and continuous growth of both the quantity and quality of services for their retarded.

THE SCANDINAVIAN PROGRAMS FOR THE MENTALLY RETARDED

CONCLUSIONS

We had been reading and hearing about Scandinavian programs for the retarded for many years. We "knew" when we started our study of them that they could not be as uniformly good as they had been represented to be. We returned from this study convinced that they were even better!

What makes them better? Many things together contribute to this. Money is a big factor. Having a retarded child is no longer a financial burden in Scandinavia. The child receives a pension as soon as he is accepted on the Register, and continues to receive it as long as he has need of it. Hospitalization and medical care are provided by Social Security. In both Denmark and Sweden there are sufficient residential facilities for all who prefer to live in an institution than in their own home. These institutions provide a level of care and other amenities that are difficult to equal.

The attitude of the general public is reflected in the bearing of the retarded. The public is interested in them and supports the high costs of providing for them. Even though their taxes are high, in providing for the mentally retarded and their other social services, they generously support voluntary organizations which are devoted to their cause. The result is that we observed no apparent feeling of insecurity on the part of the many retardates whom we saw and to whom we talked.

One cannot visit Scandinavian facilities without noticing the absence of negative thinking about the mentally retarded. An outstanding example of this is the sheltered workshop we reported visiting in Uppsala, Sweden, where they will not hire instructors who have had previous employment experience in working with the retarded. They do not want instructors who may have preconceived ideas as to the limitations of those whom they will be training.

Their attitudes towards individual dignity, privacy, sexual needs and the rights enjoyed by the general public, all contribute to the over-all enlightened program.

We regret that the five weeks which we had in which to make this survey was insufficient time to learn as much as they have to teach. We feel we did learn that it is evidently profitable for society to provide good programs, and at as early an age as possible. In many of the countries where we have made similar studies, it is considered too difficult to teach trainables to become employable. There is no such attitude in Scandinavia. The result is that a large proportion of them have become taxpayers.

Whenever we have been planning for a study of mental retardation programs in other countries, we have faced the problem of learning which agencies and institutions we should visit, and to whom we should correspond in

setting up appointments. In every case we have found Dr. Rosemary Dybwad (wife of Gunnar Dybwad) to be a gold mine of information. She not only knows who the people are, but is also very generous in sharing this information with us. Without her assistance, we fear that much of our time in making these studies would have been much less productive.

We are also indebted to Mr. Harvey Stevens, Director of the Bureau of Mental Retardation for the State of Wisconsin, and the first President of the International Association for the Scientific Study of Mental Deficiency. He not only wrote letters to his counterparts in Denmark and Sweden, but also made many helpful suggestions. The fact that he is Mrs. Clark's "boss", provided us with an entree wherever he was known, and we found but few people in the field of mental retardation who did not either know him or at least know of him.

The first words which we learned in any of the Scandinavian languages were "tack sa mycket". We had so many occasions to say, "thank you," that we would have been extremely ungracious if we had not said it, and in their own language. Their hospitality and generous sharing of ideas and information leaves us indebted to them.

Neither one of us have had training in all of the disciplines which are involved in the broad programs which the Scandinavians have developed. Even if we had more knowledge in these many disciplines, we would not have had sufficient time to make the studies in depth which they deserve. Instead, we did what we call "bird dogging." We hunted for, observed and secured information about ideas, plans and programs which we believe to be different from curs, and which might be worth studies in greater depth by those with training in special education, vocational training, psychology and other professions, and will enable them to fully appreciate and study them.

To enable them to know where to go, and whom to contact, we are listing a few of these people and institutions from whom we secured much of the information in this report.

SOURCES OF INFORMATION

DENMARK

Institutions and Agencies

Danish National Service for the Mentally Retarded
Falkoner Alle' 1
Copenhagen F, Denmark

Bornehospitalet i Vangede
Sognevej 40, 2820 Gentofte
Copenhagen, Denmark

Centralinstitutionen Lillemosegard
Buddingevej 163, 2860 Soborg
Copenhagen, Denmark

Folstrup
(Nursing Home for Women)
Nodebo 3480
Fredensborg, Denmark

Karens Minde
(Residential home for the profoundly retarded)
Wagnersvej 19
2450 Copenhagen SV, Denmark

Individuals

Dr. N. E. Bank-Mikkelson, Director
Statens Adnssvageforsorg
Falkoner Alle' 1
2000 Kobenhavn F, Denmark

Mrs. Elna Skov
(Director of hostel for mentally retarded women)
Frydendalsvej 13
Copenhagen V, Denmark

Mrs. Birgit Kirkebaek
(Superintendent training school for retarded children)
Mose Alle' 8, 2610 Rodovre
Copenhagen, Denmark

Landsretssagforer Albert Christensen, President
Landsforeningen Evnesvages Vel
(National Society of the Mentally Retarded)
Vester Voldgade 96
DK 1552 Copenhagen V, Denmark

SOURCES OF INFORMATION

SWEDEN

Dr. Karl Grunewald
Head of Division of Care of the Mentally Retarded
Socialstyrelsen
Wallingatan 2, Sweden

Miss Ingrid Gunnas
(Social worker assistant to Dr. Grunewald)
Socialstyrelsen
Wallingatan 2, Sweden

Mr. Goran Hagerberg, Director
Sofielundshemmet
(Residential institution)
73040 Kolback, Sweden

Mr. Allan Anderson, Kanslichef
(Director of residential institution)
Box 77
77600 Hedemora, Sweden

Miss Marie-Louise Foogde
(Psychiatrist at above institution)

Dr. Henrik Swaitling, Psychiatrist-medical director
Omsorgsstyrelsen (Residential institution)
Rickombergh
Box 12044
75012 Uppsala, Sweden

Dr. Ingemar Olow, Director
Bracke Ostergard Pediatric Habilitation Center
Gothenburg, Sweden

Riksforbundet FUB
(Parent organization)
Hantverkargaten 32, Stockholm, Sweden

Syster Esters Vardhem
Mr. Kihlman, Owner
(A privately owned residential institution for young children)
Lodose, Sweden

SOURCES OF INFORMATION

NORWAY

Mrs. Kari Bredal
(Volunteer Red Cross worker with the mentally retarded and Chairman of the Board of Grimebakken--a residential home for 120 MR's)
Gabelsgate 32 C
Oslo, Norway

Mrs. Edith Arnesen, Director
Ragna Ringdals Daghjem
(Day school for 145 MR's)
Hans Nilsen Haugesgt.44
Oslo 4, Norway

Oslo Observasjonhjem
(Diagnostic and evaluation center)
Kyrre Greppsgt. 11
Oslo 4, Norway

Mr. Tormod Larsen, Director
Fossheim Verksteder
(Sheltered Workshop)
Thv. Meyersgt. 11
Oslo 5, Norway

BROCHURES AND PUBLICATIONS

Wherever we visited, we asked if they had printed material on their facility, or any literature regarding mental retardation in their country. We wanted this material for our own use in preparing this report, for future reference, and to loan to others who are interested in specific subjects.

Below is a listing of the material we gathered, and which is available for loan to anyone who requests it.

DENMARK

Brochures (In English)

General Survey and Brief History of the Development of Social Systems in Denmark, Edited by The National Service for the Mentally Retarded, 1969

Rehabilitation and Care for the Handicapped

The Danish National Service for the Mentally Retarded, Survey of Organization

Social Provision for the Mentally Handicapped, Dr. Bank-Mikkelson

The Ideological and Legal Basis of the National Service of the Treatment, Teaching, Training, etc., of the Mentally Retarded, as well as a Description of the Structure of the National Service, Dr. Bank-Mikkelson, 1964

The Cripples Building Society - A report by a society which sponsors building and apartments for the special needs of cripples

The Society and Home for Cripples in Denmark, a report by the above

Ten Years of Planning and Building, by the National Service for the Mentally Retarded, 1959 - 1969, a beautifully illustrated description of residential facilities for the mentally retarded, built during the past ten years.

Mimeographed Material (In English)

A Five Year Forecast of the Demands for Institutional Care on the Island of Funen, Denmark, by Elith Berg, 1969

Circular Letter No. 21, January 21, 1969 on allocations of responsibility and authority among the center executives.

Circular Letter No. 22, February 22, 1969, on meetings to be held regularly, inservice training, with parents and with clients

Minde Lecture, 1967, Dr. Bank-Mikkleson, an over-all report on mental retardation services in Denmark

The Rehabilitation Act of 1960, as amended in 1966

Symposium on Guardianship, Dr. Bank-Mikkelson at the International Congress on Mental Deficiency, San Sebastian, 1969

The Frequency of Mental Retardation in Denmark, Elith Berg

Danish Research on Mental Retardation, 1968

The Structure of the Danish National Service for the Mentally Retarded, An Urban Model, Dr. Bank-Mikkelson

Workshop Activities for the Mentally Retarded in Denmark, Elith Berg, 1969

Mental Retardation Service In Denmark, a review and description

Community Services for the Mentally Retarded, Dr. Bank-Mikkelson

Sterilization and Castration Act, 1967, a translation

The Mental Deficiency Welfare Centre for Copenhagen, a description of Lillesmosegard

A description of a hostel for young girls, written by Mrs. Elna Skov, the director

The Exercise of Mental Care and the Sexual Life of the Mentally Retarded, a talk given by Chief Physician, Henry Olsen

Results and Problems After Screening for Five Years for Phenylketonuria, by Erik Wamberg, M. D.

Facilities for the Mentally Handicapped in Australia, by Dr. Bank-Mikkelson

Statistical Survey of the Retardation Services in Denmark, February 1970

Annual Total Cost Per Client for Different Types of Institutions for the Year 1968 - 1969

Curriculum, 1969 term, The Personnel Training School, Copenhagen.

Brochures and Publications (In Danish)

Furuly - Barneheim, a description of institutions in one area

S. A. -nyt the June, 1970 magazine of the parents organization

Haemmet Udvikling, a description of mental retardation and the services provided for the care of the retarded

Lillesmosegard, two illustrated brochures describing the residential institution

Bornehospitalet I Vangede, an illustrated brochure on the children's hospital for the mentally retarded in Copenhagen

Oversight over Institutioner m. v., a listing of all institutions in Denmark for the mentally retarded, by regions.

SWEDEN

Brochures (In English)

The Mentally Retarded in Sweden, Karl Grunewald, an over-all description of Swedish philosophy, policies and practices for the mentally retarded

Services for the Handicapped, Richard Sterner, Ph. D., background, planning, provisions and facilities for all handicapped

Social Policy and How It Works, Ake Fors, a review of social welfare in Sweden

Social Benefits, 1970, a listing of all of the types of social benefits available.

Mimeographed Papers (In English)

The Normalization Principle and Its Human Management Implications, Bengt Nirje

The Outlines of the New Swedish Mental Retardation Law, 1968, Bengt Nirje

Towards Independence, Bengt Nirje, a paper for the meeting "The Retarded Adult in the Community," with World Congress of the International Society for Rehabilitation of the Disabled--Dublin, Ireland, 1969

Biennial Report for FUB, the Swedish National Association for Retarded Children, 1968

Individual Rights of the Retarded, Allan Evritt, a paper given at the 1967 Symposium of International League of Societies for the Mentally Handicapped, Stockholm, 1967

Rights of the Mentally Retarded, Richard Sterner Ph. D., President of the Swedish National Association for Retarded Children (FUB). Paper given at International Conference of Social Welfare, Helsinki, 1968

Future Role of Guardians of Mentally Retarded Persons, Allan Evritt, Barrister, and Richard Sterner, Ph. D., ILSMH Symposium on Guardianship, San Sebastian, Spain, 1969

A short description of the Work at the Home for the Mentally Retarded, Sofielundshemmet, Stromsholm, by Goran Palmestal, Director

Myelomeningocele, three papers presented at a joint meeting of the Scandinavian Neurosurgical Society and the Scandinavian Association of Pediatric Surgeons, Gothenburg, 1966, on spina bifida and myelomeningocele

Adaptation in Cerebral Palsy of Body Composition, Nutrition and Physical Working Capacity at School Age, by Kristina Bard, in collaboration with four other doctors

Fact Sheets on Sweden, an informational brochure on social insurance in Sweden.

Mimeographed Papers (In Swedish)

Allman Halsooch Sjukvard, 1967, Official Statistica on Public Health in Sweden

Klinisk klassificering av CP-syndromen hos barn, by Ingemar Olow and four other doctors. A clinical classification of the cerebral palsy syndrome.

NORWAY

Brochures (In English)

Hospital Acts of June 19, 1969. Revised legislation establishing facilities and shared costs of the care of the mentally retarded. Social Insurance in Norway, 1969.

Mimeographed Papers (In English)

The Structure and Function of the Service for the Mentally Retarded, 1969

The HELP Organization for the Mentally Handicapped in Oslo - a report on this organization's activities during 1969

Service for the Mentally Retarded in the Oslo Region, 1969.

Mimeographed Papers (In Norwegian)

Helsedirektoret Kontoret for Psykiatri, a listing of all institutions for the mentally retarded, with statistical breakdown

Oslo Rode Kors Barnehjelp, a 1968 report on Red Cross activities and programs for the retarded

Helseport, Gunnar Mathiesen, a scientific report on athletic activities for the mentally retarded

Stottelaget for Andssvake I Oslo, annual reports of the parent organization for the years 1958 through 1969.